

HAMPTON PARKS AND RECREATION DEPARTMENT
SCHOOL AGE PROGRAMS

MEDICAL INFORMATION

Child's Full Name: _____ Child's Birthdate: _____

Physician's Name: _____ Physician's Phone: _____

Current Health Problems or Allergies: _____

Current Medications: _____

Limits or Restrictions due to health reasons? _____

PARENTAL CONSENT FOR TREATMENT

This is to certify that I/We have Hospitalization Insurance with: Company: _____ Policy Number: _____

Do we have permission to give any medical treatment necessary to your child in case we are unable to contact you? Yes___ No___

Any exceptions? Please specify: _____

The Parent or Guardian will be responsible for picking up an ill child immediately upon notification from the staff.

Parent or Guardian will provide, within 30-days of admission, written proof of a Physicians Examination by a Licensed Physician to Practice Medicine using the State Health Department screening examination form.

I/We the undersigned, do hereby authorize that the certified medical centers/hospitals are given the authority to render necessary medical services to my/our child(ren) which results, directly or indirectly, from his/her participation in trips, programs, events, activities by the City of Hampton Parks and Recreation Department; and I/We, the undersigned; also hereby agree to be responsible for such charges made by medical center/hospital, doctor, etc., in providing such medical services as are referred to above.

Parent/Guardian Signature

Date

Witness Signature

Date

ASSUMPTION OF RESPONSIBILITY/RISK

I am aware of the general nature of the _____ program sponsored by the City of Hampton's Parks and Recreation Department, and I hereby assume responsibility for myself/my child(ren) to participate as well as the risks of participation in such a program. I agree to indemnify and hold harmless the City of Hampton, its agents/employees from any loss, damage, claim, demand, liability, or expense incurred as a result of any damage to property or person, caused by me/my child(ren) while participating in the program named above. I declare to the best of my knowledge and belief that I/my child(ren) are in sufficiently good health and physical condition to participate in the program. I agree that I/my child(ren) will, to the best of our knowledge, abide by any physical limitations which limit our activities or ability to participate in this program/activity.

Parent/Guardian Signature

Date

Witness Signature

Date